

Case Number:	CM14-0144004		
Date Assigned:	09/12/2014	Date of Injury:	03/11/2014
Decision Date:	10/14/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	09/05/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 45-year-old male, who reported injury on 03/11/2014. Mechanism of injury was not submitted for review. The injured worker has diagnosis of L5-S1 discopathy and disc herniation syndrome with left lower extremity radiculopathy. Past medical treatment consists of aquatic therapy, acupuncture, physical therapy, lumbar epidural steroid injections, and medication therapy. Medications consist of Norco, Motrin, Prozac, Lipitor, and Pepcid. On 07/08/2014, the injured worker complained of low back pain. It was noted on physical examination that the injured worker had a pain grade of 5/10 to 7/10. Examination of the lumbar spine revealed that there was significant tenderness in the paralumbar musculature. The injured worker had sciatic stretch sign and a positive straight leg raise test on the left at 40 to 45 degrees in both the supine and seated positions. Contralateral straight leg raise testing did produce back pain on straight leg raise testing of 65 to 70 degrees, both in seated and supine positions. The sacroiliac joints were stable on stress testing. The midline lumbar spine, from the thoracic spine down, had significantly reduced range of motion. There was paraspinous muscle spasm on the left. The paraspinous spasm was accentuated on range of motion. Forward flexion was 20 degrees, and extension was 5 degrees. Right and left side bending were 5 degrees. Sensation in the lumbar spine was decreased. Treatment plan was for the injured worker to continue the use of medication and receive IM injections of vitamin B12 and Toradol. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Norco 5/325 #60 with Two Refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Norco Page(s): 75, 78.

Decision rationale: The request for Norco 5/325 #60 with Two Refills is not medically necessary. California MTUS Guidelines recommend short acting opioids such as Norco for controlling chronic pain. For ongoing management, there should be documentation of the 4 A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior. There should also be an assessment indicating what pain levels were before, during, and after medication administration. The submitted documentation did not indicate the efficacy of the medication. Furthermore, there was no indication that the medication was helping the injured worker with functional deficits. Additionally, there was no drug screen or urinalysis submitted for review showing that the injured worker was in compliance with medications. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Retrospective Intramuscular Injection 2cc Toradol: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketorolac (Toradol, generic available) Page(s): 72.

Decision rationale: The request for Retrospective Intramuscular Injection 2cc Toradol was not medically necessary. The California MTUS does not recommend the use of Toradol for minor or chronic painful conditions. Submitted documentation did not submit a rationale for the IM injection of Toradol. Additionally, the efficacy of the medication was not submitted for review. Given that the MTUS does not recommend the use of Toradol and the lack of evidence submitted for review, the request for Retrospective Intramuscular Injection 2cc Toradol was not medically necessary.

Retrospective Intramuscular Injection of Vitamin B-12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Vitamin B

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Vitamin B

Decision rationale: The request for Retrospective Intramuscular Injection of Vitamin B-12 was not medically necessary. Official Disability Guidelines do not recommend the use of vitamin B

for the treatment of chronic pain. Vitamin B is frequently used for treating peripheral neuropathy, but its efficacy is not clear. A recent meta-analysis concluded that there are only limited data in randomized trials testing the efficacy of vitamin B for treating peripheral neuropathy and the evidence is insufficient to determine whether vitamin B is beneficial or harmful. As per guidelines above, the use of vitamin B is not recommended per ODG. As such, the request for Retrospective Intramuscular Injection of Vitamin B-12 was not medically necessary.